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U.S. Department of Labor

Office of Administrative Law Judges
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CASE NOS.: 2000 -BLA-680
2000-BLA-1008

In the Matter of
RONALD B. WETZEL, and MARY E. WETZEL,
Survivors of MAX E. WETZEL
Claimants

v.

GREENWICH COLLIERIES,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Robert J. Bilonick, Esq., and Heath M. Long, Esq.,
For the Claimant

John J. Bagnato, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a consolidated now deceased living miner's claim and a now deceased surviving widow's claims for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on August 30, 1999 and May 12, 2000, respectively. The Act and

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis;[2] and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimants, the surviving spouse and adult disabled child of Max Wetzel, filed their survivors' claims for black lung benefits on August 30, 1999 and May 12, 2000, respectively. (Director's Exhibit (DX) 1). An initial finding of entitlement was made on Mrs. Wetzel's claim. Interim benefits were paid to Mrs. Wetzel. (DX 43). On March 28, 2000, the employer contested the determination and requested a formal hearing. (DX 42). Mrs. Wetzel died on April 9, 2000. On April 14, 200, Mrs. Wetzel's case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. The case was assigned to me on March 15, 2001. The employer contested the Director's award of benefits to Ronald Wetzel, on July 19, 2000. (DX 21). On August 10, 2000, Ronald Wetzel's case was forwarded for a hearing. (DX 27).

On July 19, 2001, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant and employer were represented by counsel.[3] No appearance was entered for the Director, OWCP. The parties were afforded the full opportunity to present evidence and argument. Director's exhibits ("DX") 1-27 and DX 1- 48 were admitted into the record. Claimant's exhibits ("CX") 1-12 and employer's exhibits ("EX") 1-7 were likewise admitted.

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[2] Claims filed on or after Jan. 1, 1982 (with an exception for survivors of miners who died on or before Mar. 1, 1978 (20 C.F.R. §718.306)). 20 C.F.R. § 718.1. This applies to Mrs. Wetzel's claim.

[3] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(*en banc*), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

Interim benefits were paid by the Black Lung Disability Trust Fund beginning August 1, 1999, and ending for Mrs. Wetzel with augmentation for one dependent, and beginning April 1, 2000 and continuing to the present for Ronald Wetzel. (DX 47; DX 25). Mr. Wetzel had previously filed claims, on September 19, 1980, and, on May 8, 1999.

ISSUE

Whether the miner's death was due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Survivorship

The parties did not contest and I find the claimants are and were eligible survivors of a miner.

B. Coal Miner

The parties did not contest and I find the claimant's husband was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least forty-four years. (TR 13).

C. Date of Filing

The claimants filed their claims for benefits, under the Act, on August 30, 1999 and May 12, 2000. (DX 1; DX 1). The matter was not contested and I find none of the Act's filing time limitations are applicable; thus, the claim was timely filed.

D. Responsible Operator

GREENWICH COLLIERIES is the last employer for whom the claimant worked a cumulative period of at least one year and agreed it is the properly designated responsible coal mine operator in this case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001), Part 725 of the Regulations.[4] (DX 5, 26).

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[4] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R. § § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or

E. Dependents

The miner had only his wife as a dependent for purposes of augmentation of benefits under the Act, until his death. (DX 1). She passed away on April 9, 2000. She had Ronald Wetzel as her sole dependent.

F. Personal, Employment, and Smoking History

The decedent miner was born on January 30, 1924. (DX 1). He married Mary E. Wetzel, on September 11, 1945. He worked, underground, in the coal mines for forty-four years. He last worked in the coal mines in July 1984. He stopped working then, at age sixty, because of a back injury and breathing problems. (DX 46-1). Mr. Wetzel died at age seventy-five, on August 17, 1999. (DX 1).

There is evidence of record that the claimant's respiratory disability was due, in part, to his history of cigarette smoking.[5] He could have smoked up to 90 pack years, stopping at age 66. (EX 1, p. 6).

II. Medical Evidence

A. Chest X-rays[6]

There were some sixty-two readings of about forty X-rays taken between 9/5/68 and 6/18/99. (Appendix A). Most of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R.

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after Jan. 19, 2001). To rebut the first, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). Neither, presumption has been rebutted in this case.

[5] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[6] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

§ 718.102 (b).[7] Thirty of the readings are positive for pneumoconiosis.[8] Thirty-one of the readings are negative. The remainder are inconclusive. Most readings are by physicians who are A-readers, B-readers, board-certified radiologists, or both.[9] The most recent readings by a dually-qualified reader, Dr. McCloud, are positive for CWP. Considering the relative qualifications of the readers, and the number and consistency of the readings, I find twenty-six of the forty X-rays positive for CWP.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation. (MVV). The test results are used to assess lifetime respiratory disability.

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compre-hension Cooper-ation**	**Qualify* Conform ****	**Dr.'s Impression**
Bradley 11/14/80 EX 1	56 72"	2.4	96	3.0	No	Poor	No* No**	Invalid from poor cooperation.

[7] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999)(En banc). Judge did not err considering a physician's x-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on x-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (under 20 C.F.R. § 718.203, causation)."

[8] According to the American Thoracic Society (ATS):

> In interstitial diseases with small rounded or irregular opacities, such as coal workers' pneumoconiosis or asbestosis, respectively, the correlation between physiologic and radiographic abnormalities is poor. The only exception is when there is radiographic evidence of progressive massive fibrosis (PMF). As the PMF intensifies, there is frequently a significant reduction in the ventilatory capacity.

Guidelines to the Evaluation of Permanent Impairment, AMA 3rd Edition (Revised 1990) at 118.

[9] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. §37.51. Courts generally give greater weight to x-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Compre-hension Cooper-ation**	**Qualify* Conform ****	**Dr.'s Impression**
Tsai 11/25/80 DX 45-12	56 72"	2.28	63	2.77	Yes	Good Good	Yes* Yes**	
Miners' Hosp. 5/12/89 EX 1	65 72"	2.06		3.34	Yes		No* Yes**	Cox finds consistent with obstructive lung disease.
Ignacio 5/23/89 5/24/89 DX 46-14	65 72"	1.65	62.74	2.68	Unk	Good	Yes*	Impairment from COPD and CWP. Cox finds invalid. (EX 1). McQuillan finds valid.
Solic 9/11/89 DX 46-24	65 72"	1.63 1.76+	46 55*	2.82 3.38+	Yes	Good	Yes* Yes** Yes* Yes**	Cox finds moderate obstructive lung disease. (EX 1).
Patrick 2/17/98 DX 9; 40	74 70"	1.15 1.29+		2.52 2.61+		Good Good	Yes* Yes*	Moderately severe restrictive & obstructive lung disease.

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)).

+Post-bronchodilator.

For a miner of the height of 72" inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.04 for a male 74 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.63 or an MVV equal to or less than 82; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test.[10] Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

[10] According to the American Thoracic Society (ATS) "For interstitial lung disease, the FVC has proved to be a reliable and valid index of significant impairment." Guidelines to the Evaluation of Permanent Impairment, AMA 3rd Edition (Revised 1990) at 119.

Height	Age	FEV_1	FVC	MVV
72"	56	2.28	2.89	91
72"	65	2.13	2.73	85
70"	74	1.85	2.39	74
72"	74	2.04	2.63	82

C. Arterial Blood Gas Studies [11]

Blood gas studies are performed to detect an impairment in the process of aveolar gas exchange.[12] This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The test results are used to assess lifetime respiratory disability. Twenty sets of AGS were conducted with varying results between 11/14/80 and 3/1/99, several of which were conducted while the miner was on oxygen and or hospitalized. (APPENDIX B). The vast majority had non-qualifying values.

C. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

Dr. John A. Michos, Board-certified in internal medicine with a sub-specialty in pulmonary diseases, reported, in a brief one-page letter, dated November 18, 1999, that the miner had simple CWP secondary to eighteen years of coal mine employment ending in 1989. (DX 12). He listed

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[11] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:

In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . . .

(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

[12] 20 C.F.R. § 718.105(d) (Applicable Jan. 19, 2001) states:

"If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death."

[(e) In the case of a deceased miner, where no blood gas tests are in substantial compliance with paragraphs (a), (b), and (c), noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results. This provision shall not excuse compliance with the requirements in paragraph (d) for any blood gas study administered during a hospitalization which ends in the miner's death.]

records he had reviewed. He reported evidence of severe COPD, CAD, cerebrovascular accidents, and hepatocellular cancer (HCC), all of which "contributed equally to his death." Dr. Michos agreed with Dr. Solic that the COPD was most likely caused by his smoking. He then wrote: "[H]owever, a concomitment contribution from simple CWP cannot be excluded as a small but contributing factor to his lung disease and ultimately his death from COPD and other medical problems." (DX 12). This letter did not reveal a reasoned analysis.

The employer submitted the comprehensive consultative report, dated April 20, 2000, of Dr. John B. Cox, who is Board-certified in internal medicine with sub-specialties in pulmonary medicine and allergy and immunology. (EX 1). He comprehensively reviewed and summarized the miner's medical history and smoking history. He incorrectly noted the miner had twelve years of coal mine employment although reiterating longer periods, i.e. 35 years, set forth in the other records he summarized. He also reviewed a series of X-rays, finding no CWP. (EX 1, p.8-9). He observed while the X-rays showed a profusion of low degree abnormalities consistent with CWP, the more sensitive CT of shortly before his death, failed to reveal any opacities consistent with CWP. Moreover, the opacities seemed to "come and go" which is inconsistent with CWP. Dr. Cox wrote, "[W]hether his coal dust exposure contributed any measurable degree of his obstructive lung disease is argumentative. . ." He found the miner's progressive obstructive lung disease compatible with cigarette smoking. (See also Dep. p. 7). Dr. Cox determined the cause of death was the miner's hepatocellular carcinoma. He found no relationship between the miner's progressively severe obstructive lung disease and his death. He opined Mr. Wetzel would have died at the same time and in the same manner had he suffered from an occupational lung disease due to coal dust exposure. (EX 1; See also Dep. 10).

Dr. Cox testified at a deposition on September 8, 2000. (EX 5). He reiterated his credentials and the substance of his earlier report. The most common cause of HCC is chronic hepatitis, but liver cirrhosis from alcoholism is the most common cause in the U.S. (Dep. 9). HCC is not related to coal dust exposure. (Dep. 10). Mr. Wetzel's CAD and moderately severe to severe pulmonary disease did not contribute significantly to his death. (Dep. 11, 13). He did not believe the miner either had CWP or had significant CWP that would contribute to his lung disease, but agreed he had an obstructive lung disease caused by smoking. (Dep. 15, 23). He did not die from COPD. (Dep. 17). He disagreed with Dr. Solic's 1988-89 opinion noting the former had not actually diagnosed CWP and that ten years later he had better information. (Dep. 8). There was no evidence here the miner was not receiving adequate oxygen in his blood stream at the time of his death such that it would affect his organs. (Dep. 17-18). He agreed however, that Mr. Wetzel had abnormal AGS. (Dep. 19). Dr. Cox does not believe simple CWP can be a substantiated cause of death. (Dep. 23).

The employer submitted the two-page consultative report, dated September 11, 2000, of Dr. Joel B. Haight, who is Board-certified in internal medicine with sub-specialties in gastroenterology. (EX 2). He reviewed unidentified medical records. He reported hepatocellular carcinoma is a relatively rare disease in North America, here incurable at the time of diagnosis, most often associated with a prior history of cirrhosis of the liver. The miner died of hepatocellular carcinoma. The

hepatocellular carcinoma was unrelated to his lung disease and the miner's chronic lung disease was unrelated to the cause of his death. (EX 2).

The employer submitted the consultative report, dated September 15, 2000, of Dr. Kevin M. Kane, who is Board-certified in internal medicine with a sub-specialty in medical oncology. (EX 3). He reviewed extensive enumerated medical records. Dr. Kane concluded the miner developed hepatocellular carcinoma of the liver from which he rapidly succumbed. The cause of death was liver failure secondary to the cancer. He added, "[W]hile Mr. Wetzel did have evidence of chronic lung disease, he had this for a number of years and I do not believe that this contributed significantly to his subsequent death. Had he not developed this malignancy, he would have had a significantly extended survival." (EX3).

The employer submitted the one-page consultative report, dated November 14, 2000, of Dr. Wayne W. Peternel, who is Board-certified in internal medicine with a sub-specialty in gastroenterology. (EX 4). He reviewed unidentified medical records. Dr. Peternel observed the ex-smoker miner had COPD and many admissions related to it. He opined Mr. Wetzel's death was due to the effects of HCC and there was no relationship between that and his underlying chronic lung disease. (EX 4; see also Dep. 11).

Dr. Peternel testified at a short deposition, on September 8, 2000. (EX 6). He reiterated the substance of his earlier report and his credentials. He described the course of HCC here. Mr. Wetzel's exposure to coal mine dust had no relationship and no effect in the course of his HCC. He disagreed with Dr. Michos' diagnoses because he believed HCC was 100 percent the only contributing cause of death. (EX 6).

Dr. John T. Schaaf is board-certified in internal medicine with a sub-specialty in pulmonary disease. (EX 7). He submitted a one paragraph letter, dated January 13, 2001. (EX 7). He had reviewed records identified in a December 12, 2000 letter from claimant's counsel. He opined the miner clearly had CWP, but it was not the cause of his death from HCC. (EX 7).

Dr. Gregory Fino is Board-certified in internal medicine with a sub-specialty in pulmonary diseases. He submitted an extremely comprehensive, 26-page, consultative report with added attachments, dated May 25, 2000, on behalf of the employer. (DX 16). While he found evidence of a disabling respiratory impairment, from asthma and smoking, Dr. Fino did not find evidence of occupational CWP. The cause of death was HCC, which is unrelated to coal mine dust inhalation. He stated it would be pure speculation to implicate any factor other than HCC leading to the miner's death.

III. Witness Testimony

Mrs. Beverly Barrett, the miner's daughter, testified that Ronald, her brother, had been blind since birth. (TR 11). He was totally dependent on her parents and lived with them until their deaths.

He continues to live in the family home watched over by his two sisters who live next door. (TR 12). Ronald draws Social Security Disability benefits of $848.00 per month as well as interim Black Lung benefits. (TR 12). She cared for Mr. Wetzel for several years prior to his death, observed him use oxygen, inhalers, and breathing treatments. (TR 14). He had used oxygen nearly ten years. (TR 15). She reported her father did little physical activity in the 1990's. (TR 15). He had been an active man when he worked. His conditioned worsened over the years. (TR 17). He would "get real short-winded quick" climbing stairs. (TR 17). Dr. Dvorchak was his family physician. (TR 17). He had seen a pulmonary and a heart doctor. (TR 17). He had stopped smoking "like a pack per day" in the 1980's. (TR 18).

IV. Hospitalizations

Voluminous hospital records were submitted by the Director.

Dr. Timothy Byrnes'(consulting cardiologist), Miner's Hospital, records between April 15, 1993 and March 1998 were submitted. (DX 8). Dr. Byrnes examined the miner and conducted objective tests, i.e., echocardiograms, EKGs, ABS, over the years. He reported dyspnea, chronic productive cough, and a history of CWP. He noted no history of emphysema or asthma. He reported the miner smoked half a pack per day for many years, but stopped in 1988. Dr. Byrnes reported severe COPD with pneumoconiosis and his impression of "pleuritic chest pain: etiology due to bronchitis or pulmonary embolus." In February 1998, he diagnosed connective tissue diseases and pericarditis believing it had a bacterial etiology. (DX 8). The miner had gall bladder surgery in February 1998. In March 1998, he noted an acute inferior MI. (EX 8). He never specifically linked the miner's afflictions to coal mine dust exposure. Dr. Byrnes also reported the miner's Feb. 1998 gall bladder surgery was complicated by acute pericarditis which was painless, but complicated by atrial fibrillation.

154 pages of records from Miners Hospital were submitted by the director. (DX 9). The records contained many X-ray readings (which indicated advanced COPD, CWP, ASCVD, cardiomegaly, metallic pellets from a 1994 gunshot, pneumonitis, increasing infiltrative changes right lung base), CT scans of the chest (showing no chest abnormality, but multiple metastatic lesions through the liver), ABS, PFS, pulse oximetries, and laboratory test results, as well as respiratory therapy requisitions and respiratory care evaluation sheets. Between 1998 and March 1999, Dr. Dvorchak diagnosed severe COPD, hypoxia, CAD, CHF, DJD, cholecystitis, post-cholecystectomy, pneumonia, hypoxemia, MI (March 1998), atrial fibrillation, pericarditis, pulmonary hypertension, and CID.

A 428-page exhibit containing the records of admissions from Miner's Hospital, dated April 12, 1993-June 6, 1999, was submitted to the district director by the employer. (DX 40). Many of the documents unnecessarily duplicated other exhibits. Many are illegible or unintelligible. The exhibit shows several hospital admissions, nursing assessments, care plans, respiratory care evaluations, treatments, objective test results, measurements, gall bladder removal, cholecystectomy, and reflect Mr.

Wetzel's chest pains and breathing problems, which included shortness of breath , chronic productive cough, dyspnea, and wheezing, among other things. Various diagnoses, by Dr. Dvorchak and others, included: chronic bronchitis, severe COPD, asthmatic bronchitis, pneumoconiosis, pneumonitis, mild CHF, CAD, CID, acute respiratory distress, pleuritic chest pain from bronchitis or pulmonary embolus, pneumonia, myocardial ischemia, myocardial infarction, gun shoot wounds, hypoxemia, "question seizure, TIA, and arrhythmia", probable hypoxia, abdominal pain, chronic cholecystitis, cholethiasis, possible gall bladder disease, idiopathic pericarditis, atrial fibrillation, heart injury, no metastatic bone disease, normal brain CT, and hepatocellular carcinoma per biopsy. Dr. Frank Conn, noted on 10/22/94, that "[T]he patient is in good health for being 70 years of age and leads an active life." This was after he was shot while hunting.

Records related to the miner's myocardial infarction from Altoona Hospital between December 8 and 12, 1998 and were admitted. (DX 10-11). Secondary diagnoses included: acute lingular pneumonia; severe COPD requiring O2 therapy; atrial fibrillation; Hx of prior cerebral vascular accidents; Hx of prior retinal artery occlusion; and, Hx of epicarditis. X-rays revealed cardiac decompensation with possible chronic interstitial fibrosis with passive atelectasis. (DX 10). Dr. Larkin assessed a severe underlying lung disease. Dr. R. Pandit, a pulmonary consultant, noted the miner's history of CWP (which was compatible with X-ray readings) and wrote the miner told him he smoked from age 16-66 averaging slightly less than two packs per day. Dr. R. Pandit's impression was: pneumonia; severe underlying COPD; chronic hypoxemia; CWP; and, acute MI.

V. Death Certificate

The death certificate lists the date of death as August 17, 1999. (DX 7). The cause of death was "Hepatocellular cancer " and other significant conditions contributing to death but not resulting in the underlying cause "severe coal pneumoconiosis and coronary artery." (DX 7). No autopsy was performed. (DX 7). The death certificate was signed by Dr. Matthew J. Dvorchak.

VI. Autopsy

No autopsy was conducted.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. There are four possible methods of analyzing evidence in a survivor's claim under Part 718: (1) where the survivor's claim is filed prior to January 1, 1982 and the miner is entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (2) the survivor's claim is filed prior to

January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (3) the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and (4) the survivor's claim is filed on or after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. The fourth, Subsection 718.205(c) applies to this claim. [13]

The Part 718 regulations provide that a survivor is entitled to benefits only where the miner *died due to pneumoconiosis*. 20 C.F.R. § 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). Under § 718.205(c)(4), if the principal cause of death is a traumatic injury or a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death.

The regulations provide and the Board has held that in a Part 718 survivor's claim, the judge must make a threshold determination as to the existence of pneumoconiosis arising out of coal mine employment, under 20 C.F.R. § 718.202(a), prior to considering whether the miner's death was due to the disease under § 718.205. 20 C.F.R. § 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

B. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [14] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis,

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[13] The survivor is not entitled to the use of lay evidence, or the presumptions at §§ 718.303 and 718.305 to aid in establishing entitlement to survivors' benefits. A survivor is automatically entitled to benefits only where the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982. However, a survivor is not automatically entitled to such benefits under a claim filed on or after January 1, 1982 where the miner is not entitled to benefits as a result of the miner's claim filed prior to January 1, 1982 or where no miner's claim was filed prior to January 1, 1982. *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988).

[14] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[15] 20 C.F.R. §718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

"...[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (CA4 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, bronchitis, asthmatic bronchitis, bronchial asthma or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983)(bronchitis secondary to coal dust within definition). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. S*ee* § 718.201(a)(2)*; Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *Youghiogheny & Ohio Coal Co. v. McAngues*, 996 F. 2d 130, 133 (6th Cir. 1993) (COPD).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted

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[15] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

and reported in compliance with 20 C.F.R. § 718.106;[16] (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[17] 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

The Third Circuit has held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams & Director, OWCP*, 114 F.3d 22 (3d Cir. June 3, 1997) *citing* 30 U.S.C. § 923(b) and *Kertesz v. Cresent Hills Coal Co.*, 788 F.2d 158 (3d Cir. 1986).

In this matter, the parties do not contest the existence of coal workers' pneumoconiosis.

Had the parties not agreed, I would have found CWP established by the X-ray and medical opinion evidence. The claimant has not established pneumoconiosis pursuant to subsection 718.202(a)(2) by autopsy or biopsy evidence. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable. There is no evidence of complicated pneumoconiosis in this case. A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). That is the case here. The majority of well-qualified physicians diagnosed CWP.

I find the claimants have met their burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994).

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[16] A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis, but positive results will constitute evidence of the presence of pneumoconiosis 20 C.F.R. § 718.106(c).

[17] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

C. Cause of pneumoconiosis

Here the parties do not dispute that the miner's CWP arose out of his coal mine employment. Once a miner is found to have pneumoconiosis, the claimant must ordinarily show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c). Since the miner had ten years or more of coal mine employment, the claimants receive the rebuttable presumption that his pneumoconiosis arose out of coal mine employment.

D. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) competent medical evidence established that the miner's death was caused by pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R. § 718.205(c). Criteria (1) and (3) are not at issue in this case; criterion (2) is not met. No physician opined that the miner's death was caused by CWP. There is no evidence of complicated pneumoconiosis. Thus, the issue is whether criterion (2) is proven.

The Board concludes that death must be "significantly" related to or aggravated by pneumoconiosis, while the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The regulation now provides that "Pneumoconiosis is a 'substantially contributing' cause of death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5). The United States Court of Appeals for the Third Circuit has also held that any condition that *hastens* the miner's death is a substantially contributing cause of death for purposes

of § 718.205. *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1006 (3d Cir. 1989). [18]

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, such as the miner's HCC, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4); *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

The Act and Regulations do not require that pneumoconiosis be the sole, primary or proximate cause of death, but rather that where the principal cause of the miner's death was not pneumoconiosis, that the evidence establish it was a "substantially contributing cause." 20 C.F.R. § 718.205(c)(4). *See, Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1005 (3rd Cir. 1989)(quoting 48 Fed. Reg. 24,276, 24,277(1), (n)(1983)).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various board certifications, and expertise, as noted above, I rank Drs. Michos, Cox, Haight, Kane, Peternel, Fino, and Schaaf equally and among the most qualified of those presenting evidence in this case. There is a distinction between a physician who merely examines a miner and one who is one of his "treating"

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[18] The Fourth, Sixth, Seventh, Tenth and Eleventh Circuits have adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. den.*,506 U.S. 1050, 113 S.Ct. 969 (1993); *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting); and *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992); *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871 (10th Cir. 1996); *Bradberry v. Director, OWCP*, 117 F.3d 1361, 21 B.L.R. 2-166 (11th Cir. 1997).

physicians.[19] I give great, but not controlling, weight to Dr. Dvorchak as a treating physician.[20] *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989) (More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically). Dr. Dvorchak treated Mr. Wetzel over an extended time period, i.e., 1993-1999, and thus had a more thorough understanding of his condition. *Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985) (the length of time in which the physician has treated the miner is relevant to the weight given the physicians' opinion); *Gomola v. Manor Mining & Contracting Corp.*, 2 B.L.R. 1-130, 1-135 (1979). Moreover, the medical records establish Dr. Dvorchak frequently treated Mr. Wetzel for his breathing problems, among other maladies.

All physicians agreed that the cause of death was the miner's rapidly spreading HCC. Dr. Dvorchak completed the Death Certificate listing as "other significant conditions contributing to death but not resulting in the underlying cause" "severe coal pneumoconiosis and coronary artery." No autopsy was conducted. Although I consider and credit Dr. Dvorchak's opinion because he was the treating physician, his credentials are unknown and there is no showing that he has any specialized expertise in cancer, HCC, or pulmonary diseases. Dr. Michos' one-page opinion that, " a concomitment contribution from simple CWP cannot be excluded as a small but contributing factor to

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[19] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994).

[20] § 718.104(d) Treating physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

his lung disease and ultimately his death from COPD and other medical problems" did not reflect a reasoned or well-documented analysis. Even he agreed the COPD was most likely caused by smoking.

It is proven Mr. Wetzel was very ill during the latter years of his life suffering from: HCC; chronic lung disease; COPD; CAD; hypoxia; CHF; cholecystitis; pneumonia; pulmonary hypertension; atrial fibrillation; MI; CID; pericarditis; DJD; hypoxemia; myocardial ischemia; gun shot; gall bladder disease; and, possibly cerebral vascular accidents, as well as cardiac decompensation.[21]

The employer's very well qualified experts, most notably Dr. Cox, all found no relationship between the miner's COPD, CWP, coal mine dust exposure and his death. Dr. Cox had the most comprehensive consultative report submitted. Moreover, Drs. Cox, Haight, Kane, Peternel, and Fino represented a variety of pertinent medical specialities, i.e., oncology, pulmonary diseases, and gastroenterology. Moreover, it appears Dr. Schaaf, who found CWP was not the cause of death, was originally the claimants' witness. Their opinions conclusively establish HCC was the immediate cause of death and that neither CWP nor coal mine dust exposure played any significant role in the miner's death.

I find that the evidence fails to establish that pneumoconiosis was a substantially contributing cause of death or that it hastened the miner's death. *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988).

G. Attorney fees

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, it is established that the miner had pneumoconiosis, as defined by the Act and Regulations at the time of his death and that the pneumoconiosis arose out of his coal mine employment. However, it is not proven that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death. The claimants are therefore not entitled to benefits.

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[21] His PFS demonstrate he most likely suffered from a disabling respiratory disease although his AGS results were mixed.

ORDER

It is ordered that the claims of RONALD B. WETZEL, and MARY E. WETZEL for benefits under the Black Lung Benefits Act are hereby DENIED.

A

RICHARD A. MORGAN
Administrative Law Judge

RAM/dmr

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**.[22] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[22] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001).

(d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

APPENDIX A

Exh. #	Dates 1. X-ray 2. read	Physician	Qualific-ations	Qual-ity	Classif-ication	Interpretation or Impression
DX 45-46	9/5/68	Schornick				Micronodule CWP.
DX 45-46	1/24/79				1/1	
DX 45-46	1/14/80	Bradley			0/1, q	
DX 45-16	11/25/80	Lull	BCR		0/0	
DX 45-17	11/25/80	Marshall	B; BCR		2/1, P, 6 LZ	
DX 45-46	11/27/88	Rice	BCR			Fibrotic changes.
DX 45-46	11/28/88	Stanliewicz	B; BCR			Compatible with CWP.
DX 45-46	11/30/88	Rice	BCR			Nodular/fibrotic changes.
DX 45-46	1/9/89	Rice	BCR			Fibrotic changes.
DX 45-46	1/11/89	Rice	BCR		0/0	
DX 45-46	4/1/89	Rice	BCR		0/0	
CX 4	4/5/89 12/6/00	Mathur	BCR; B	1	1/1, p/q, 6 LZ	
DX 45-46	4/5/89	Stankiewicz	B; BCR			Compatible with CWP.

Exh. #	Dates 1. X-ray 2. read	Physician	Qualific-ations	Qual-ity	Classif-ication	Interpretation or Impression
DX 40	4/12/93 4/13/93	Tirpak	DO			COPD with associated pneumoconiosis.
DX 45-46	4/17/89	Stankiewicz	B; BCR			
DX 45-46	5/24/89	Rice	BCR			CWP.
DX 45-19	5/24/89	Greene	B; BCR		1/1, r/r, 2 LZ	
DX 45-24	9/11/89	Solic	B; BCR		0/0	
DX 45-46	4/12/93	Tirpak	BCR			CWP.
DX 45-46	10/21/94	Stankiewicz	B; BCR			Compatible with CWP.
DX 45-46	10/23/94	Stankiewicz	B; BCR			CWP.
DX 40	10/24/94	Conn	Radio-logist			Diffuse reticulonodular pattern both lungs, with Hx of CME, findings compatible with CWP. Hyperinflation compatible with COPD.
DX 40	10/23/94	Stankiewicz	DO			CWP, COPD, no acute cardiopulmonary pathology.
CX 2	10/23/94 9/26/00	Mathur	BCR; B	1	1/1, q/t, 4 LZ	
DX 40	11/15/96	Tirpak	DO			COPD. Early cardiomegaly.
CX 3	11/15/96 12/6/00	Mathur	BCR; B	2	1/1, q/q, 4 LZ	

Exh. #	Dates 1. X-ray 2. read	Physician	Qualific-ations	Qual-ity	Classif-ication	Interpretation or Impression
DX 40	2/7/98	Tirpak	DO			Advanced COPD.
DX 16	2/7/98 5/25/00	Fino	B		0/0	No CWP.
CX 1	2/7/98 9/26/00	Mathur	BCR; B	3	1/0, q/t, 3LZ	Very poor visualization of opacities from over-exposure.
CX 5	2/24/98 12/6/00	Mathur	BCR; B	2	1/0, q/q, 3 LZ	Lower 1/3 R lung is opacified from unknown lung pathology.
DX 16	2/24/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	2/23/98	Stankiewicz	DO			COPD. CWP.
DX 40	2/28/98 3/1/98	Stankiewicz	DO			No acute cardiopulmonary pathology.
CX 6	2/28/98 12/6/00	Mathur	BCR; B	1	1/1, q/t, 4 LZ	
DX 16	2/28/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	4/12/98	Stankiewicz	DO			COPD. Pneumonia.
CX 7	4/12/98 12/6/00	Mathur	BCR; B	1	½, q/t, 4 LZ	Opacification in lower R Lung could be from vascular accident.
DX 16	4/12/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	4/14/98	Stankiewicz	DO			COPD, CWP, ASCVD.
CX 8	4/15/98 12/6/00	Mathur	BCR; B	1	½, q/q, 4 LZ	Some fibrotic changes lower R lung.
DX 16	4/15/98 5/25/00	Fino	B		0/0	No CWP.

Exh. #	Dates 1. X-ray 2. read	Physician	Qualific-ations	Qual-ity	Classif-ication	Interpretation or Impression
DX 40	12/18/98	Stankiewicz	DO			COPD, CWP, ASCVD. Cardiomegaly, pneumonitis.
CX 9	12/08/98 12/6/00	Mathur	BCR; B	1	½, q/t, 3 LZ	Partial opacification of R lung base is possibly from edema.
DX 16	12/08/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	2/18/99	Tirpak	DO			Resolving basilar infiltrates.
CX 10	2/18/99 12/6/00	Mathur	BCR; B	2	1/1, q/t, 4 LZ	
DX 16	2/18/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	2/19/99	Tirpak	DO			Resolving basilar infiltrates. Cardiomegaly.
CX 11	2/20/99 12/6/00	Mathur	BCR; B	1	½, q/t, 4 LZ	
DX 16	2/20/98 5/25/00	Fino	B		0/0	No CWP.
DX 40	3/2/99 3/3/99	Stankiewicz	DO			Increasing infiltrative changes RL base.
DX 14, 40	3/1/99 3/1/99	Tirpak	DO			COPD w mild basilar infiltrates. Cardiomegaly.
DX 15	3/1/99 10/26/99	McCloud	B; BCR	1		No CWP.
DX 16	3/3/99 3/3/99	Stankiewicz	DO			Increasing infiltrates RL base. LL relatively clear.
DX 17	3/3/99 10/26/99	McCloud	B; BCR	2		No CWP. Opacities both bases, probably atelectasis.

Exh. #	Dates 1. X-ray 2. read	Physician	Qualific-ations	Qual-ity	Classif-ication	Interpretation or Impression
DX 18, 40	3/4/99 3/5/99	Tirpak	DO			Resolving pneumonitis RL.
DX 19	3/5/99 10/26/99	McCloud	B; BCR	2	1/1, q/s, 2 LZ	Opacities not well seen on prior films.
DX 20, 40	3/10/99 3/10/99	Stankiewicz	DO			RL infiltrative changes resolved. COPD, ASCVD, mild CWP.
DX 21	3/10/99 10/26/99	McCloud	B; BCR	1	1/1, q/q, 2 LZ	
DX 40 CT scan	6/15/99 6/15/99	Stankiewicz	DO			Metastatic liver disease.
DX 22, 40	6/18/99 6/18/99	Tirpak	DO			No evidence of abnormality seen at chest CT. Multiple metastatic lesions in liver.
DX 23, 40	6/18/99 6/18/99	Tirpak	DO			COPD w/o evidence of abnormality.
DX 24	6/18/99 10/26/99	McCloud	B; BCR	2	1/1, q/q, 2 LZ	

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; R- Radiologist; BCP-Board-Certified Pulmonologist; BCI- Board-Certified Internal Medicine; BCCC- Board-Certified Critical Care. Readers who are board certified radiologists and/ or B readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Decided under Part 727 of the Regulations).

APPENDIX B

Date Ex.#	**Physician**	**pCO_2**	**pO_2**	**Qualify**	**Physician Impression**
11/14/80 EX 1	Bradley	34	87	No	Cox finds normal. (EX 1).
11/24/80 11/25/80 DX 45-15	Tsai	32 30+	72 75+	No No	Cox finds mild degree of baseline hyperventilation with normal oxy-genation. (EX 1).
11/28/88 EX 1	Miners' Hosp.	42	**96**	No	
1/9/89	Miners' Hosp.	28	69	Yes	
1/10/89	Miners' Hosp.	37	75	No	On O2.
4/1/89	Miners' Hosp.	31	67	Yes	
4/17/89	Miners' Hosp.	43	82	No	
4/18/89	Miners' Hosp.	43	82	No	
5/23/89 5/24/89 DX 46-16	Ignacio	33 35+	72 73+	No No	McQuillan finds valid.
9/11/89 DX 46-25	Solic	39 35+	64 75+	No No	Disabled from chronic bronchitis. Cox finds hypoxemia.
11/15/96 EX 1	Miners' Hosp.	45	67	No	
2/7/98	Miners' Hosp.	41	71	No	On O2.

Date Ex.#	Physician	pCO_2	pO_2	Qualify	Physician Impression
2/17/98	Miners' Hosp.	42	67	No	
2/20/98 EX 1	Miners' Hosp.	42	67	No	On O2.
2/28/98	Miners' Hosp.	34	60	Yes	
3/1/98 EX 1	Miners' Hosp	34	60	Yes	
4/11/98	Miners' Hosp.		69	Unk	
4/12/98	Miners' Hosp.	38 55+	69 101+	No Yes+	On O2.
2/18/99 EX 1	Miners' Hosp.	40	58	Yes	
EX 1 3/1/99	Miners' Hosp.	41	71	No	While on O2.

A lower level of oxygen (O2) compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

* Results, if any, after exercise.

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."